



Michigan Sleep Therapy - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

The best time to contact me is: Morning Mid-Day Evening on Home phone Cell phone Work phone

Email Address _____ Would you like to receive our e-newsletter? Yes No

Address: _____ City: _____ State: ____ Zip: _____

Date of Birth (M/D/Y): ____ / ____ / ____ Gender: M F Social Security Number (SSN): _____

Height: Feet ____ Inches ____ Weight (lbs): ____ Marital Status: Married Single Life Partner Minor

Spouse or Parent/Guardian (if minor) Name: _____

Emergency Contact: _____ Relationship: _____ Phone _____

REFERRED BY: _____

Employer Information

Employer: _____ Phone: (____) _____ Fax: (____) _____

Address: _____ City _____ State: ____ Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: Self Spouse Child Other

Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____ / ____ / ____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address _____ City _____ State: ____ Zip _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? YES NO IF **YES**, PLEASE COMPLETE THIS SECTION

Patient's Relationship to Insured: Self Spouse Child Other

Name of Insured (First, MI, Last): _____ Insured DOB ____ / ____ / ____

Ins Co.: _____ Ins ID: _____

Group #: _____ Plan Name: _____

Business Address _____ City _____ State: ____ Zip _____

Phone :(____) _____ Fax: (____) _____ Email: _____

Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____

ENT: _____ Phone: _____

SLEEP DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

OTHER MD: _____ Phone: _____

OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date: _____



Michigan Sleep Therapy Patient Questionnaire

EPWORTH SLEEPINESS SCALE

- Sitting and Reading _____
- Watching TV _____
- Sitting inactive in public place (theater) _____
- As a car passenger for an hour without a break _____
- Lying down in the afternoon to rest _____
- Sitting and talking to someone _____
- Sitting quietly after lunch without alcohol _____
- In a car while stopped at a traffic light _____

- 0 = No chance of dozing
- 1 = Slight Chance of dozing
- 2 = Moderate Chance of dozing
- 3 = High Chance of dozing

TOTAL = _____

THORNTON SNORING SCALE

- My snoring affects my relationship with my partner _____
- My snoring causes my partner to be irritable or tired _____
- My snoring requires us to sleep in separate rooms _____
- My snoring is loud _____
- My snoring affects people when I am sleeping away from home _____

- 0 = Never
- 1 = 1 night/week
- 2 = 2-3 nights/week
- 3 = 4+ nights/week

TOTAL = _____

Please list the main reason(s) you are seeking treatment for snoring or sleep apnea:

Do you have other complaints?

- | | |
|---|--|
| <input type="checkbox"/> Frequent snoring | <input type="checkbox"/> Difficulty maintaining sleep |
| <input type="checkbox"/> Excessive Daytime Sleepiness (EDS) | <input type="checkbox"/> Choking while sleeping |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Feeling unrefreshed in the morning |
| <input type="checkbox"/> Waking up gasping / choking | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Neck or facial pain | <input type="checkbox"/> Nasal problems, difficulty breathing through nose |
| <input type="checkbox"/> I have been told I stop breathing when I sleep | <input type="checkbox"/> Irritability or mood swings |
| <input type="checkbox"/> Other: _____ | |

Subjective Signs and Symptoms

Rate your overall energy level (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Rate your sleep quality (Low) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Have you been told you snore? YES / NO / SOMETIMES

Rate the sound of your snoring (Quiet) 1 2 3 4 5 6 7 8 9 10 (Loud)

On average, how many times per night do you wake up? _____

On average, how many hours of sleep do you get per night? _____

How often do you awaken with headaches? NEVER / RARELY / SOMETIMES / OFTEN / EVERYDAY

Do you have a bed partner? YES / NO / SOMETIMES Do you sleep in the same room? YES / NO

How many times per night does your bedtime partner notice you stop breathing?

SEVERAL TIMES PER NIGHT / ONCE PER NIGHT / SEVERAL TIMES PER WEEK / OCCASIONALLY / SELDOM / NEVER



Michigan Sleep Therapy Patient Questionnaire

Have you ever had a sleep study? YES NO
If YES, where and when? _____ Date: _____

Have you tried CPAP? YES NO
Are you currently using CPAP? YES NO
If YES, how many nights per week do you wear it? _____ / 7 Nights
When you wear your CPAP, how many hours per night do you wear it? _____ hours per night

If you use or have used CPAP, what are your chief complaints about CPAP?

- Mask leaks
- An inability to get the mask to fit properly
- Discomfort from the straps or headgear
- Decrease sleep quality or interrupted sleep from CPAP device
- Noise from the device disrupting sleep and/or bedtime partner's sleep
- CPAP restricted movement during sleep
- CPAP seems to be ineffective
- Device causes teeth or jaw problems
- A latex allergy
- Device causes claustrophobia or panic attacks
- An unconscious need to remove CPAP at night
- Caused GI / stomach / intestinal problems
- CPAP device irritated my nasal passages
- Inability to wear due to nasal problems
- Causes dry nose or dry mouth
- The device causes irritation due to air leaks
- Other: _____

Are you currently wearing a dental device? YES NO
Have you previously tried a dental device? YES NO
If YES, was it Over the Counter (OTC)? YES NO
Was it fabricated by a dentist? YES NO If YES, who fabricated it? _____

If applicable, please describe your previous dental device experience:

Have you ever had surgery for snoring or sleep apnea? YES NO

Please list any nose, palatal, throat, tongue, or jaw surgeries you have had.

DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____
DATE: _____ SURGEON: _____ SURGERY: _____

Please comment about any other therapy attempts (weight loss, gastric bypass, etc.) and how each impacted your snoring and apnea and sleep quality.



Michigan Sleep Therapy Patient Questionnaire

PRE-MEDICATION – Have you been told you should receive pre-medication before dental procedures? YES NO

If YES, what medication(s) and why do you require it? _____

ALLERGENS -- Please list everything you are allergic to (for example: aspirin, latex, penicillin, etc):

MEDICATIONS – Please list all medications you are currently taking:

MEDICAL HISTORY – Please list all medical diagnoses and surgeries from birth until now (for example: heart attack, high blood pressure, asthma, stroke, hip replacement, HIV, diabetes, etc):

Dental History

How would you describe your dental health?	EXCELLENT	GOOD	FAIR	POOR
Have you ever had teeth extracted?	YES	NO	→ If YES, please describe _____	
Do you wear removable partials?	YES	NO		
Do you wear full dentures?	YES	NO		
Have you ever worn braces (orthodontics)?	YES	NO	→ If YES, date completed: _____	
Does your TMJ (jaw joint) click or pop?	YES	NO	→ Do you have pain in this joint?	YES NO
Have you had TMJ (jaw joint) surgery?	YES	NO		
Have you ever had gum problems?	YES	NO	→ If YES, have you ever had gum surgery?	YES NO
Do you have dry mouth?	YES	NO		
Have you ever had an injury to your head, face, neck, or mouth?			YES	NO
Are you planning to have dental work done in the near future?			YES	NO
Do you clench or grind your teeth?			YES	NO

If you answered YES to any question above, please briefly describe your answer here:

Family History

Have genetic members of your family had:

Heart Disease? YES NO **High Blood Pressure?** YES NO **Diabetes?** YES NO

Have genetic members of your family been diagnosed or treated for a sleep disorder? YES NO

How often do you consume alcohol within 2-3 hours of bedtime? Daily Occasionally Rarely/Never

How often do you take sedatives within 2-3 hours of bedtime? Daily Occasionally Rarely/Never

How often do you consume caffeine within 2-3 hours of bedtime? Daily Occasionally Rarely/Never

Do you smoke? YES NO **If YES, how many packs per day?** _____

Do you use chewing tobacco? YES NO **If YES, how many times per day?** _____

PATIENT SIGNATURE

I certify that the information I have completed on these forms is true, accurate, and complete to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____